Flagstaff Medical Center
1200 N. Beaver St.
Flagstaff, AZ 86001
928-779-3366

Steven Lewis, MD, FCCP
Chief Medical Officer, Sr. Vice President
928-773-2495
Steven.lewis@nahealth.com

We appreciate the opportunity to respond from the provider perspective to the AHCCCS RFI concerning Greater Arizona Behavioral Health Services. The alignment and integration of payer and provider resources in Population Health Management initiatives designed to improve behavioral and physical health is a complex issue. Fundamentally, we believe that the following principles are important in designing such a system:

- New payer-provider relationships should be partnerships focused on mutually-agreed upon Population Health outcomes, rather than contractual payment relationships.
- Fund distributions should be aligned with and incentivize Population Health concepts of best health, best care, and best cost (i.e. the "Triple Aim").
- Care management programs that integrate acute physical and behavioral health services, chronic care programs, and individual health enhancement should serve as the core of collaborative Population Health Management work. Such care management programs should include community resources as well as payer and provider resources and establish common leadership, outcome goals, and financial incentives.
- Inefficiency and ineffectiveness in health care delivery largely result from non-productive variation in care provision. Appropriate variation reduction is essential to reducing healthcare waste. Collaborative provider-payer initiatives that are data-driven will expedite variation reduction and enhance the effectiveness of evidence-based practice models.
- Changing payer structure and regional relationships with providers has noteworthy risk of unintended consequences. Existing provider-payer relationships that have demonstrated improvements in care through pilot programs and data-sharing initiatives should not be ignored in statewide planning to integrate behavioral and physical health care. Such legacy relationships should be considered in the size and scope of Greater Arizona Behavioral Health Service planning and contracting.

5.1 *What opportunities exist for restructuring the Greater AZ GSAs? What regional geographical approach should the state consider when creating the RFP? North? South?*

Arizona is sufficiently large and diverse to benefit from both a North and South GSA. Such an approach would help ensure that collaborative relationships and care processes can develop and be sustained with the diverse communities and cultures in the North and South regions. It would also foster collaborations that sufficiently understand regional and local sub-populations so that service implementation planning can appropriately incorporate cultural, geographic, and other strengths and needs into operational processes.

5.2 *In the event that the state opts to consolidate Greater Arizona's existing regions and to select 2 vendors to serve Greater Arizona in whole, what would the benefits, challenges, and risks be?*

A single Greater AZ GSA may not be able to accomplish the collaborations necessary for the successful and sustainable integration of physical and behavioral health services. Sufficient differences in existing regional partnerships, prior efforts and demonstration projects, and community needs and cultures make the option of a North and South GSA approach preferable. Consistent communication and committed dialogue – among collaborators in a geographic region – will be a key component of success. This will be especially important when operational planning expands with Tribal RBHAs in support of Tribal beneficiaries receiving care outside of Tribal reservation communities.

5.3 *What are the challenges and opportunities of establishing the following Term of Contract options?*

A 5 year contract term may be too long and could be problematic if the awardee is not able to establish the collaborations with local and regional providers necessary for improved outcomes and reduced costs. Consequently, either option 5.3.1.1 or 5.3.1.3 (3 year terms with extensions) seems optimal.

5.4 *What are the implications of the State implementing a statewide crisis system? How can crisis services be more effectively delivered in Greater Arizona?*

Crisis services, particularly mobile crisis services, are problematic in rural Arizona as geography creates barriers to service. In addition, crises often develop outside of the service area for a person's designated Responsible Agency. Crises with a concomitant medical emergency often result in hospitalizations outside of patients' designated service area, without clear processes for rapid assessment and planning during the hospitalization. Finally, crisis services must accommodate the involvement of numerous law enforcement agencies.

In Coconino County, the problem is aggravated by a lack of coordination with County-contracted T-36 assessments for emergency involuntary admission. Processes for crisis services and involuntary treatment assessments often become competitive, fragmented, and exclusionary despite the obvious benefits of shared processes and combined financing.

A statewide crisis system holds the potential to standardize expectations and processes that would cross different jurisdictions and service areas. However, the risk of developing an inflexible system that will fail because of such rigidity is substantial. A statewide system, if implemented, would need to set uniform service standards while allowing flexible and localized processes to achieve those standards.

It is recommended that the bidder be required to:

- Delineate a process for crisis assessment and intervention for persons during an acute medical hospitalization, including immediate enrollment and care management. This should include the provision of clinical staff who either meet hospital credentialing requirements or are already credentialed by that hospital. This process should be defined in agreements with each hospital.
- Coordinate or contract with Counties for the inclusion of T-36 involuntary assessments and services in the crisis services plan.
- Delineate a process that insures every person who undergoes a T-36 assessment is offered additional crisis and treatment services when involuntary treatment is not indicated.
- Delineate the scope of mobile crisis services in differing geographic areas, and how such services will be delivered.
- Delineate the expected role of law enforcement related to crisis services and have agreements with law enforcement agencies that define these expectations.
- Delineate a process for follow up contact with each person after a crisis intervention, including service enrollment, with a goal of facilitating access to services even if the person has left the immediate service area.

5.7 *When it comes to service delivery, how will your organization utilize regional and cultural diversity to its maximum advantage in order to provide physical and behavioral health care in Greater Arizona?*

Patient cultural beliefs and practices should be key components of a fully integrated physical-behavioral health care model. There is ample experience to date demonstrating the value of including such beliefs and practices in service delivery. Provider-payer partnerships should leverage this experience, while concurrently reducing variations in clinical processes that presently result in fragmented and inconsistent care for patients with SMI. A successful awardee must have strong relationship with Tribal RBHAs and regional non-payer providers so that consistent operational processes can be designed, implemented, and adhered to. These models should also aim to reduce care coordination staff redundancies that may already exist among the payer-provider partners.

5.10 *What specific measures and processes should be used to evaluate access to care and improved outcomes?*

Programmatically, access to integrated care can be assessed by evaluating the presence of centralized care management services and in turn ensuring that most chronic disease care is coordinated through those care management services. Metrics to consider include: a) the percentage of SMI patients with chronic disease who have a centralized care manager, and b) the percentage of care delivered as per care process models, on recommendation of care management.

Access to care may also be more directly evaluated by:

- The frequency of ED admissions and inpatient admissions/observations. This applies to both physical and behavioral concerns.
- The frequency of first contact with a primary care provider for most acute physical and behavioral health needs.

- Timeliness and completion of the first outpatient visit following a crisis contact, or after any hospitalization.

Consistent clinical goals and care plans are vital for improved individual care. Care management supports should work with providers to identify goals and care plans. Timely information system access and collaborative metrics among payers and providers supporting SMI patients with physical health needs is essential. This will help assure that all those caring for these patients have a common understanding of any individual patient's status, treatment plan, and needs.

5.11 *What are the current barriers for health information system and technology that support the sharing of individual health information for improved care coordination and health outcomes, and what steps can be taken to overcome them?*

There appear to be challenging policy and regulatory differences regarding protected physical and behavioral health information. Clear guidance on the management of "Part 2" privacy regulations - and options for securely sharing or re-disclosing PHI for SMI patients with substance abuse and co-existing physical conditions - will significantly improve timely clinical access to protected health information for this patient population, regardless of where patients access services. In addition, a strategy and timeline for integrated health information sharing at the state level (i.e. Health Information Exchange of AZ) will aid efforts at collaborative care management.

5.12 *What is the most effective way to engage the community and stakeholders in Greater Arizona, and how should a RBHA be held accountable to those parties?*

Community organizations and stakeholders are critical to the successful care of patients with SMI and physical health needs. Social, housing, and other needs must be considered key elements of an integrated care model. A RBHA should work with the clinical and social provider network to a) agree on a care model that includes diverse resources and supports and b) develop common goals, processes, and outcome metrics. The RBHA awardee should then share information on progress towards identified goals in a timely and regular fashion if there is to be trust established among collaborators and real change enacted for the population served.

5.14 *What payment models should be considered to incentivize health outcomes, access to care, and cost efficiency for Greater Arizona?*

Steady movement toward shared risk and clinical accountability among payers, behavioral health providers, and acute care providers will be necessary.

Suggestions regarding general principles for new payment model include:

- Payment reform without payer-provider partnerships focused on better health care and better health will have, at best, short-term benefit. Financial incentives alone are inadequate to create the robust access, effectiveness, and efficiency changes needed. They may also run the substantial risk of short-changing the populations served. In the long term, such shortfalls for patients will result in higher and sustained costs. Successful payer-provider partnerships should address:
  - Mutual, integrated care management programs, jointly funded;
  - Timely access for providers to claims-base data;
  - Actuarial support for provider decision-making.

- Many Arizona providers are ill equipped to immediately engage in risk-sharing relationships beyond a shared savings approach.
- Shared saving programs are a first step toward more comprehensive risk sharing provider-payer relationships
- Provider success in managing risk is largely dependent upon the ability to reduce variation in care and to develop robust care management programs. Payer contributions to these initiatives through data sharing can be very meaningful for care process model development. The cost of care management programs can be shared.
- Payer mindset toward providers (and vice versa) is key to structuring such partnerships. Financial incentives should not focus only on the amount paid and the amount received.
- Providers have high fixed costs that are very slowly modified. Variation reduction in care processes primarily reduces variable costs. It will take time for providers to adjust cost structures. Consequently, the proper pace and expectation in cost reduction is important.

Risk sharing should be tiered.

- As already noted, an initial tier of shared savings can be productive and lead to more robust risk sharing at a later time.
- Structured risk pools for various components of care, with downside limits for providers, can be a meaningful subsequent step, helping providers be successful with risk sharing.
- Global risk assumption for providers is a goal that will take time.
- Providers must have significant actuarial support to know when and how to participate in downside risk contracts. Appropriate payer partners could assist with this.

Fundamentally, the strongest alignment for improved population health involves providers and payers participating in risk assumption together. This will represent a huge change for most Arizona providers. Sufficient time and pace must be permitted so that providers may make the necessary cost structure changes.